the FRVS rate. This will be converted to a per diem by dividing by 90 percent of the maximum annual bed days of the facility and by 75 percent of the maximum annual bed days for newly constructed facilities. Again, for those facilities that have put into service new beds for the first 12 months, and the addition of beds was 50 percent or more of the existing bed capacity, or the addition of 60 beds or more, the twenty percent will be converted to a per diem by dividing by a weighted average occupancy percentage greater than 75 percent but less than 90 percent of the maximum annual bed days as explained in 1) and 2) above.

f. (1) The interest rate used to amortize the 80 percent component of the asset valuation shall be the lower of: the owner's actual mortgage rate; the Chase Manhattan Bank's prime rate as of the date of the provider's loan commitment plus 2 percent for a variable-rate mortgage or plus 3 percent for a fixed mortgage rate; or 15 percent. If an owner has more than one outstanding debt instrument, the owner's actual rate used for this section shall be an average of the rates for all of the outstanding debt, weighted by the amount of the original principal of each debt instrument.

(2) No changes subsequent to establishment of the initial FRVS rate shall be made to the interest rate used to calculate the FRVS rate for providers with fixed-rate mortgages except as allowed per (5) below. For variable-rate mortgages, no changes shall be made unless the owner's interest rate changes according to (3) below.

(3) For the initial FRVS rates at October 1, 1985, the July 1, 1984 Chase prime shall be used for the "lesser of" comparison with the provider's actual rate. For those providers that received the July 1, 1984 Chase prime (13%) at June 30, 1996, (referenced above) beginning with the July 1, 1996, rate semester, these same providers shall have 12.5% used for the "lesser of" comparison on and after July 1, 1996. For rate semesters prior to July 1, 1996, these same providers shall remain at 13%. Providers shall be required to notify the Agency of their mortgage rate and any changes in their mortgage rate. Providers with variable mortgage rates shall submit current changes in their mortgage rates by October 15 and April 15 of each year to qualify for an adjustment to their FRVS rate on the following January 1 or July 1, respectively. At that time, the FRVS rate to be used for the next 6-month rate semester beginning January 1 or July 1 shall be determined using the most current mortgage rate, but not to exceed the October 15 or April 15, respectively, Chase-Manhattan prime plus 2 percent, or 15 percent.

(4) For facilities beginning the FRVS with a total initial principal balance of the mortgages less than 60 percent of their indexed asset value, the interest rate used to amortize the 80-percent component shall be the applicable Chase prime as detailed above, but not to exceed 15 percent. The amortization of prime over 20 years shall be used to determine an amount which would pay interest on an

installment mortgage for that 80-percent valuation. The prime rate used to initiate FRVS for providers with an initial principal balance of the mortgage less than 60 percent of their indexed asset value shall remain fixed for that provider in calculating future FRVS payments. However, if at some point in the future a provider finances capital assets such that the total original principal of debt instruments equals or exceeds 60 percent of the FRVS asset valuation, then the FRVS rate at the next rate semester shall be calculated using the interest rate per (1) above.

(5) An increase in the interest rate shall be allowed only if refinancing was necessary in order to finance the addition of new beds or to meet the final payments of the former debt instrument, or to consolidate existing debt excluding debt to owners; for example, in cases where balloon payments are due. If a new mortgage is secured at the addition of new beds and a prior mortgage is still in effect for the original facility, a weighted average mortgage rate shall be used in (1) above based upon mortgage amounts and interest rates of the various mortgages.

g. The standard, or ceiling, per-bed cost shall be established at $28,500.00 at October 1, 1985. Each existing facility at October 1, 1985, shall have its total capital assets valuation limited to that standard or the facility's computed asset valuation, whichever is less. The standard of $28,500.00 shall be indexed forward every 6 months based upon the most recently published 6-month full increase in the FCCI Index and shall be used to limit new construction costs in the future. New facilities shall be limited to the standard in effect 6 months prior to the date the facility was first put into service as a nursing home. A facility shall not receive an adjustment to account for increases in the standard at later dates.

h. A "hold harmless" provision shall be implemented to ensure that facilities existing and enrolled in the Medicaid program at October 1, 1985, do not receive reimbursement for property and return on equity or use allowance under the FRVS method less than the property cost reimbursement plus return on equity or use allowance given at September 30, 1985. If, after calculation of the FRVS rate, that reimbursement would be lower than depreciation plus interest costs under III.G. 3.-5. of this plan, a facility shall continue to be reimbursed depreciation plus interest according to III.G. 3.-5. of this plan until such time as the net difference in total payments between III.G. 3.-5. and FRVS is zero. Providers who wish to begin FRVS reimbursement that would result in payments less than the depreciation plus interest payments must notify the Agency in writing by December 2, 1985. Facilities with existing leases at October 1, 1985, shall be paid at the September 30, 1985 rate subject to III.G.2. until the current lease expires, at which time reimbursement shall begin under FRVS based on the owner's acquisition costs. Providers shall supply the Agency with the appropriate lessor's ownership costs to receive property reimbursement after the current lease expires. No reimbursement for property-related costs shall be given to a leased facility subsequent to the expiration of the lease existing at

October 1, 1985, if the lessor's ownership costs are not adequately documented per Section III.G.4. of this plan.

i. Facilities existing and enrolled in the Medicaid program at October 1, 1985, shall be phased up to their FRVS rate in equal percent increments based upon the following schedule:

YEAR OF ENTRY INTO MEDICAID PROGRAM	YEARS TO FULL FAIR RENTAL VALUE FROM OCTOBER 1, 1985
December 31, 1971 or earlier	4
1972	5
1973	6
1974	7
1975	8
1976	8
1977	9
1978	9
1979	10
1980	10
1981	10
1982	10
1983	10
1984	10
January 1, 1985 through September 30, 1985	10
October 1, 1985 and after	-0-

FRVS rates shall be calculated according to subsections a. through g. above, but actual payments made during the applicable years of phase-in starting at October 1, 1985 shall be limited to the reimbursement rate effective as of September 30, 1985, exclusive of property taxes and insurance, plus a portion of the difference between that rate and the newly-computed FRVS rate. The portion of the difference allowed shall be a function of the number of years applicable to attaining full FRVS as shown above for various facility entry dates. A facility with a 4-year phase-in shall receive payments based on one-fourth of the difference for rates at October 1, 1985, January 1, 1986, and July 1, 1986; two-fourths of the difference for rates at January 1, 1987 and July 1, 1987; three-fourths of the difference for rates at January 1, 1988 and July 1, 1988; and four-fourths of the difference for rates at January 1, 1989 and thereafter. Similarly, a facility with an 8-year phase-in shall receive payments based on one-eighth of the difference for rates at October 1, 1985, January, 1, 1986 and July 1, 1986; two-eighths of the difference at January 1, 1987 and July 1, 1987; and so on, until attaining eight-eighths of the difference for rates at January 1, 1993 and after.

j. Subsequent to October 1, 1985, no adjustments to asset valuation shall

be made for replacements of existing equipment for those facilities fully phased to FRVS payments. Adjustments at cost shall be allowed for capital improvements and additions. Capital additions of beds shall be subject to the per bed standard as computed in g. above that is in effect 6 months prior to the date the facility addition was first put in service as a nursing home. An adjustment to the FRVS rate may be requested if expenditures for capital additions and improvements totaling $0.40 per available bed day accrue in the cost reporting period utilized in establishing the per diem rate for the upcoming rate semester. Costs incurred during a cost reporting period that do not total $0.40 per available bed day shall not be included in the next cost reporting total. Thus, a 120-bed facility purchasing new equipment which does not replace any old equipment, and making capital improvements at a total unamortized purchase cost less than $17,520 during a twelve month cost reporting period shall not receive an adjustment to the FRVS rate in the coming rate semester or in any rate semester for those improvements or equipment. The cost of capital additions or improvements shall be established on the date new beds are put into service, the date of completion for capital improvements, and date of acquisition for equipment or other purchased assets and recognized for FRVS purposes so long as the total indexed asset valuation does not exceed the current per bed standard except as provided below:

(1)(a) Effective July 1, 1996, providers whose indexed asset valuation exceeded the per bed standard at June 30, 1996, shall be limited to their June 30, 1996, indexed value until the rate period in which their total asset value is less than the current per bed standard.

(1)(b) Providers that entered into a legally enforceable arms length agreement prior to July 1, 1996 for the construction or purchase loans of additions (excluding bed additions) or improvements which were not previously reported in a cost report shall have those additions or improvements included in their indexed asset value when the cost report that includes those additions or improvements is used to establish the reimbursement rate. When the above above mentioned additions or improvements cause the providers indexed asset value to exceed the current per bed standard, the provider shall be limited to that indexed asset value until the rate period in which that indexed asset value is less than the current per bed standard. Documentation of the legally enforceable, arms length agreement must be submitted with the cost report in which the additions or improvements are reported.

(2) In no other circumstances other than in (1)(a) and (1)(b) above shall a provider's total asset value under FRVS exceed their current per bed standard.

(3) Any cost associated with capital additions or improvements which are not recognized in the FRVS rate due to the per bed standard limitation, shall not be allowed in any future FRVS rate.

Adjustments made to FRVS rates due to capital additions or improvements shall be subject to retroactive adjustment based on audit findings made by AHCA. For facilities with 5 to 10 years remaining to full FRVS phase-in, 50 percent of replacement cost shall be reimbursed as a pass-through cost as depreciation and interest expense; if 4 years are remaining in the phase-in, 40 percent; if 3 years remaining, 30 percent; 2 years remaining, 20 percent; and 1 year remaining, 10 percent. This pass-through reimbursement shall be recaptured by AHCA in entirety if the facility undergoes a change of ownership.

2. FRVS for facilities entering the Medicaid program subsequent to October 1, 1985.

a. The FRVS rate for facilities constructed subsequent to October 1, 1985 or existing facilities which enter the Medicaid program subsequent to October 1, 1985 shall be calculated as in 1.a.-h. and j. above. These facilities shall not be subject to any phase-in to the FRVS rate, and shall not have the option to elect reimbursement under Section III. G. 2. - 5.

b. The ceiling that shall apply to facilities entering the program subsequent to October 1, 1985 shall be the ceiling in effect 6 months prior to the date the facility was first put into service as a nursing home. For facilities built prior to October 1, 1985 which enter the program subsequent to October 1, 1985, the ceiling at October 1, 1985 shall be deflated, using the FCCI Index, back to 6 months prior to the date the facility was first put into service as a nursing home.

3. Facilities that are currently participating in the Medicaid program but subsequently withdraw.

a. Facilities that participate in the Medicaid program on or after October 1, 1985 but subsequently withdraw shall be subject to the same cost per bed ceiling that they were previously subject to should they decide to re-enter the program.

b. At re-entry into the program, the indexing of asset valuation shall resume at the point where the facility was in the 40-year indexing curve per E.1.c. above when it withdrew from the program.

4. Property reimbursement for facilities upon change of ownership.

a. Facilities that undergo a change of ownership on or after October 1, 1985 shall be reimbursed for property based upon the provisions contained in this section. It is the Agency's intent that, to the extent possible, the new provider shall receive essentially the same reimbursement for property costs as the previous provider. Therefore, unless stated otherwise in b. through f. below, the new provider's reimbursement shall be based on 1.-3. above.

b. If the previous owner of a facility was being paid depreciation plus interest under the hold harmless provision of 1.h. above, the new owner shall also receive depreciation plus interest per Section III.G. unless he requests the Agency, in writing, to begin FRVS payments instead. The FRVS depreciable basis shall remain the same as that of the previous owner; interest expense allowed, subject to the limitations in 1.f. above.

c. If the previous owner was being reimbursed under FRVS, the new owner shall also receive FRVS payment, entering at the point of phase-in and asset value indexing that the previous owner had reached. If the new owner's principal balance of all current mortgages is less that 60 percent of the indexed asset value, only the interest portion, at a rate determined in 1.f.(4), will be used in calculating the new owner's FRVS rate. If the new owner's principal balance of all current mortgages is equal to or greater than 60 percent of the indexed asset value, then the new owner shall be paid principal and interest on 80 percent of the total asset valuation amortized over 20 years at the interest rate specified in 1.f.(1) above. In addition, the new owner's interest rate shall be used in lieu of the original owner's interest rate in accordance with the limitations described at 1.f.(1). above. Any credits accrued by the previous owner for indexing as described in 1.b. above shall be applied to the new owner.

d. The return on equity or use allowance shall be calculated as per 1.e. above. A per diem shall be calculated for property taxes and insurance, based upon actual historic cost and patient days shown in the latest applicable cost report, as per 1.e. above.

e. The new provider shall be subject to the recapture provisions in Section III.H. of this plan. The new provider's cost basis shall be computed per III.G.3. of this plan.

f. Reimbursement to a new provider for costs of replacement equipment shall be governed by the same provisions affecting the previous provider. The new provider shall enter the phase-in schedule at the point reached by the previous provider at the change of ownership, and shall be reimbursed per 1.j. above for replacement costs.

5. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Medicaid certification effective on or after July 1, 1991.

	Example 1	Example 2
New Facility Cost	$3.0 Million	$4.0 Million
CON Approval	$2.8 Million	$3.0 Million
Medicaid Allowable Cost	$2.5 Million	$3.5 Million
Reimbursable Cost	$2.5 Million	$3.0 Million

Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example above, the reimbursable cost which is considered in rate calculations, is the lower of the new facility cost, CON approval, or the Medicaid allowable cost.

F. Medicaid Adjustment Rate (MAR)

For rate periods beginning on and after July 1, 1996, the Medicaid Adjustment Rate shall be calculated as follows:

1. Facilities with 90% or greater Medicaid utilization shall have their MAR equal their WBR as determined in the formula below.

2. Facilities with 50% or less Medicaid utilization shall receive no MAR.

3. Facilities between 50% and 90% Medicaid utilization shall have their MAR as determined by the following formula:

MAR = WBR x MA
WBR = (BR x MAW) X **((Superior + Standard)/All).**
MA = ((Medicaid Utilization % - **MIN)/(MAX-MIN))** X 100

Definitions:

MAR = Medicaid Adjustment Rate
WBR = Weighted Base Rate
MA = Medicaid Adjustment
BR = Base Rate, which is set as the results of step V.B.19.e
MAW = Medicaid Adjustment Weight, which is set at .045
Superior =Number of Superior Days as described in section V.D.2.(a)
Standard = Number of Standard Days as described in section V.D.2.(a)
All = All superior, standard, and conditional days
MIN = Minimum Medicaid Utilization Amount which is set at 50%
MAX = Maximum Medicaid Utilization Amount which is set at 90%

The result of these calculations will represent the **MAR** to which the provider is entitled. This rate is to be included in the patient care component of the provider's total reimbursement rate.

G. Case-Mix Adjustment

For the rate period beginning on April 1, 1999 through June 30, 1999 and for rate periods beginning on and after July 1, 1999, a case-mix adjustment will be calculated and paid as an add-on to the patient care component of the per diem rate.

A. 1. AHCA will utilize the Minimum Data Set (MDS) Assessments being submitted by nursing facilities to calculate an average case-mix score for each nursing facility participating in the Medicaid program. The average case-mix score will be computed by using the most current version Resource Utilization Grouper (RUGS III), as published by HCFA, to classify the MDS assessments into one of thirty-four (34) RUGS III categories. An additional category will be added as a default, which will be assigned the lowest case-mix weight, for those MDS assessments that can not be classified. For purposes of calculating the case-mix score only MDS assessments for Medicaid residents will be utilized to establish the average case-mix score.

a. For the rate period April 1, 1999 through June 30, 1999 the MDS assessments filed for the period October 1, 1998 through February 28,1999 will be used to calculate the average case-mix score. For each July 1 and January 1 rate period subsequent to June 30, 1999 the MDS assessments submitted for the periods October 1 through March 31 and April 1 through September 30, respectivelywill be used in the calculation of the average case-mix score.

b. For the applicable periods as described in Section V.G.1.a. above a case-mix score will be calculated for each MDS assessment submitted for a Medicaid resident. The total case-mix score for each resident will be weighted by the number of days covered by the MDS assessment. Upon computing each individual's weighted case-mix score an average case-mix score will be computed for the facility using all Medicaid residents.

c. An average case-mix score will be calculated for all nursing facilities participating in the Medicaid program as of April 15 and October 15 preceding the July 1 and January 1 rate semesters, respectively. New providers, as defined in V.G.1.d. below, entering the Medicaid program subsequent to the April 15 and October 15 dates will not receive a case-mix adjustment until the following January 1 and July 1 rate semesters, respectively. For the rate period April 1, 1999 through June 30, 1999 only those nursing facilities participating in the Medicaid program as of

February 28, 1999 will receive a case-mix adjustment to the patient care component of their total reimbursement rate.

d. For new providers entering the Medicaid program the average case-mix score will be the minimum established under Section V. G. 2.a.below. New providers, for purposes of calculating the case-mix adjustment, are those in a newly constructed nursing facility or nursing facilities which have not previously participated in the Medicaid program. For existing providers undergoing a change in ownership or operator the MDS assessments submitted for the previous Medicaid provider will be used to establish the average case-mix score for the new provider.

e. No changes or corrections to the case-mix adjustment paid to a nursing facility will be made subsequent to the effective date of the case-mix adjustment.

2. The case-mix adjustment to the patient care component of the total per diem rate will be calculated using the following methodology.

   a. Upon calculating the average case-mix score for each nursing facility eligible for the case-mix adjustment, a statewide average case-mix score will be computed. The statewide average case-mix score will be the average case-mix score for all facilities eligible for the case-mix adjustment. The lowest case-mix score will be used as the minimum score for new providers, as described in V.G.1.d. above.

   b. An average case-mix rate will be used to calculate each facility's add-on and will be calculated by dividing the available dollars appropriated for the case-mix adjustment by the projected number of Medicaid days in the prospective rate period. For the April 1, 1999 case-mix adjustment the prospective period will be April 1, 1999 through June 30, 1999.

c. The add-on for each individual facility will be computed by multiplying the average case-mix rate determined in Section V.G.2.b. above times each facility's average case-mix score in Section V.G.2.a. above divided by the statewide average case-mix score, calculated in Section V.G.2.a. above.

d. If in total the add-on for each facility times that facility's projected Medicaid days does not equal the total funds appropriated for the case-mix add-on, then each facility's add-on will be proportionately adjusted to ensure that total payments for the case-mix add-on equals the available funds.

H. Direct Care Staff Adjustment (DCSA)

Effective April 1, 2000, a direct care staff adjustment will be calculated and paid as an add-on to the patient care component of the per diem rate. The Agency is to reimburse those nursing facilities who qualify and choose to receive the adjustment for the cost of hiring additional certified nursing assistants and licensed nurses or for the cost of salary or benefit enhancements to retain such staff in these specific classes.

1. The qualification criteria used to determine if a provider participates in the distribution of the DCSA includes the following:

   a. The provider must be an active Medicaid provider and submit direct care staffing, patient day and cost data for the base period of January 1, 1999 through June 30, 1999.

   b. The provider must notify the Agency of its intent to participate in the DCSA.

   c. The provider must submit a statement of how it intends to meet legislative intent in spending the DCSA.

d. The provider must agree to provide follow-up documentation as described in Section 4 below.

2. The direct care staffing ratios shall be calculated and ranked as follows:

a. From the data received for the period January 1, 1999 through June 30, 1999, the total direct staffing hours per patient day is calculated for CNAs and licensed nurses for each provider.

b. The direct care staffing ratios calculated in subsection a above are ranked from high to low.

3. The DCSA shall be calculated as follows:

a. The total annualized Medicaid days for participating providers is projected from the six-month reporting period in Section 1a above.

b. The annualized Medicaid days are multiplied by a $0.50 minimum add-on to determine the minimum amount that a provider will receive. The total minimum add-on amount for all providers is calculated.

c. The remaining amount to be allocated is calculated by subtracting the total minimum add-on calculated in subsection b above from the total amount of the DCSA.

d. All providers with a direct care staffing ratio of 5 or above will be assigned the value of 5 and will only receive the minimum amount in subsection b above.

e. All providers with a direct care staffing ratio of 2.3 or below will be assigned the value of 2.3 and will receive the maximum add-on amount available under this methodology.

f. To achieve an inversely proportionate distribution, each provider's staffing ratio is subtracted from the assigned value of 5, from subsection d above, to calculate an inverted hours per patient day. This results in providers with a lower staffing ratio receiving a higher result (e.g., 5-2.3=2.7) and providers with a higher staffing ratio receiving a lower result (e.g., 5-5=0).

g. For each provider, the Medicaid patient days are multiplied by the inverted hours per patient day as calculated in subsection f above, to arrive at a unadjusted additional add-on amount.

h. The amount calculated in subsection g above for each provider is adjusted proportionately so that the total amount for all providers equals the remaining amount to be allocated in subsection c above.

i. Each provider receives a total DCSA which includes the minimum amount in subsection b above plus the remaining amount in subsection h above.

j. No changes or corrections to the data used to calculate the DCSA shall be made subsequent to the effective date of the DCSA except as noted in sections 4 and 5 below.

4. All providers receiving a DCSA must provide documentation of direct care expenditures during the period May 1, 2000 through October 31, 2000 to demonstrate adherence to legislative intent. This documentation must be submitted to the Agency by November 30, 2000 and in a format similar to the base data period documentation. Any amount deemed not to have been appropriately expended is to be reimbursed back to the Agency.

5. When prospective rates are based on cost reports that include any of the additional costs associated with the DCSA, an appropriate adjustment to the patient care component of the per diem rate shall be made to prevent duplicative reimbursement.

VI. Payment Assurance

The State shall pay each nursing home for services provided in accordance with the requirements of the Florida Title XIX State Plan, Rule 59, F.A.C., 42 CFR (1997), and Section 1902 of the Social Security Act. The payment amount shall be determined for each nursing home according to the standards and methods set forth in the Florida Title XIX Long-Term Care Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of nursing homes in the Medicaid Program, the availability of high-quality nursing home services for recipients, and for services, which are comparable to those available to the general public.

VIII. Payment in Full

Any provider participating in the Florida Medicaid nursing home program who knowingly and willfully charges, for any service provided to the patient under the State plan, money or other consideration in excess of the rates established by the State plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the State plan approved under this title, any gift, money, donation or other consideration other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the patient as a condition of admitting a patient to a nursing facility or intermediate care facility; or as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein is paid for in whole or in part under the State plan, shall be construed to be soliciting supplementation of the State's payment for services. Payments made as a condition of admitting a patient or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Medicaid patient and shall be deemed to be out of compliance with 42 CFR 447.15 (1997).

IX. Definitions

Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

Agency for Health Care Administration : (AHCA), also known as the Agency.

Audit: Means a direct examination of the books, records, and accounts supporting amounts reported in the cost report to determine correctness and propriety.

Audit Adjustment: Means any adjustment within the Medicaid audit report or Medicaid desk review report on Attachment A.

Audit Finding: Means any adjustment within the Medicaid audit report or Medicaid desk review report not listed on Attachment A.

Desk Review: Means an examination of the amounts reported in the cost report to determine correctness and propriety. This examination is conducted from the AHCA reviewer's office and is focused on documentation solicited from the provider or documents otherwise available to the reviewer.

District: The agency shall plan and administer its programs of health, social, and rehabilitative services through service districts and subdistricts composed of the following counties:

District 1 - Escambia, Santa Rosa, Okaloosa, and Walton counties

District 2, Subdistrict A - Holmes, Washington, Bay, Jackson, Franklin, and Gulf counties

District 2, Subdistrict B - Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor counties

District 3, Subdistrict A - Hamilton, Suwanee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, and Alachua counties

District 3, Subdistrict B - Marion, Citrus, Hernando, Sumter, and Lake counties

District 4, Subdistrict A - Baker, Nassau, Duval, Clay, and St. Johns counties

District 4, Subdistrict B - Flagler and Volusia counties

District 5 - Pasco and Pinellas counties

District 6, Subdistrict A - Hillsborough and Manatee counties

District 6, Subdistrict B- Polk, Hardee and Highlands counties

District 7, Subdistrict A - Seminole, Orange, and Osceola counties

District 7, Subdistrict B - Brevard county

District 8, Subdistrict A - Sarasota and Desoto counties

District 8, Subdistrict B - Charlotte, Lee, Glades, Hendry and Collier counties

District 9 - Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach counties

District 10 - Broward county and

District 11 - Dade and Monroe counties

HCFA-PUB.15-1: Health Insurance Manual No. 15, also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Health Care Financing Administration.

Medicaid Interim Reimbursement Rate: A reimbursement rate or component of an overall reimbursement rate that is calculated from budgeted cost data. Any overpayments or under payments resulting from the difference between budgeted costs and actual costs (limited by class or statewide ceilings), as determined through an audit of the same reporting period, will be either refunded to the Agency or paid to the provider as appropriate.

Medically Fragile: Infants and children with complex medical problems are individuals, ages 0-21, who have chronic debilitating diseases or conditions of one or more physiological or organ systems which generally make them dependent upon 24-hour a day medical/nursing/health supervision or intervention. Medically fragile means an individual whose medical condition is such that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN) or is ventilator dependent.

Medicaid Nursing Home Operating Costs: Those costs not directly related to patient care or property costs, such as administrative, plant operation, laundry and housekeeping costs. Return on equity or use allowance costs are not included in operating costs.

Medicaid Nursing Home Patient Care Costs: Those costs directly attributed to nursing services, dietary costs, and other costs directly related to patient care, such as activity costs, social services, and all medically-ordered therapies.

Medicaid Nursing Home Property Costs: Those costs related to the ownership or leasing of a nursing home. Such costs may include property taxes, insurance, interest and depreciation, or rent.

Provider: Means a person or entity licensed and/or certified under State law to deliver health care or related services, which services are reimbursable under the Florida Medicaid Program.

Reimbursement Ceilings: The upper rate limits for Medicaid nursing home operating and patient care reimbursement for nursing homes in a specified reimbursement class, or, the upper limit for nursing home property cost reimbursement for all nursing homes statewide.

Reimbursement Ceiling Period: January 1 through June 30 of a given year or July 1 through December 31 of a given year.

Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395pp).

Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396i).

APPENDIX A
CALCULATION OF THE FLORIDA NURSING HOME COST INFLATION INDEX

Based on a sample size of approximately 25% of the cost reports filed for the rate period beginning January 1, 1988, the percentage weights for cost components are estimated as:

Salaries and Benefits	57.89%
Dietary	5.18%
Others	36.93%

An inflation index for each of these components is developed from the Data Resources, Inc. Skilled Nursing Facility Market Basket of Routine Services Costs inflation indices as follows:

Component	DRI Index
Salaries and Benefits	Wages and Salaries, combined with Employee Benefits
Dietary	Food
All Others	Fuel and Utilities, combined with Other Expenses

The DRI indices are combined by summing the products of each index times the ratio of the respective DRI budget share to total budget share represented by the combined indices. Example: For the fourth quarter of 1982 Health Care Costs (April, 1982 issue, p. 18)

Wages and Salaries index = 1.026; budget share = .595
Employee Benefits index = 1.062; budget share = .089
Weighted combination (Salaries and Benefits)
= (1.026 x (.595/(.595+.089))) + (1.062 x (.089/(.595+.089)))
= 1.03068

A weighted quarterly index is then constructed by summing the products of the weights and quarterly component indices. This quarterly composite index is utilized to obtain monthly indices called the Florida Nursing Home Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

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Quarter	Index	Average Index	Corresponding Month
1982: 1	0.9908	0.9954	March 31
1982: 2	1.0000	1.0078	June 30
1982: 3	1.0155	1.0236	September 30
1982: 4	1.0316		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ x (March 31 Index)
= $(1.0078/.9954)^{1/3} \times .9954$
= .9995

May 31 Index = (June 30 Index/March 31 Index)$^{2/3}$ x (March 31 Index)
= $(1.0078/.9954)^{2/3} \times .9954$
= 1.0036

All monthly indices can be calculated in a similar fashion.

These indices will be updated semi-annually prior to each January 1 and July 1. Weights for cost components will be updated based on the latest available cost data on file with AHCA.

APPENDIX B
CALCULATION OF THE FLORIDA CONSTRUCTION COST INFLATION INDEX
FOR RATES EFFECTIVE PRIOR TO 7/1/91

The Florida Construction Cost Inflation Index is calculated by combining certain indices in the semiannual quarterly publication, Dodge Building Cost Indices for U.S. & Canadian Cities, published by McGraw-Hill. The Florida Index is calculated by the following steps:

1. Compute the average Dodge Index for the six Florida cities listed in the publication: Fort Myers, Jacksonville, Miami, Orlando, Tallahassee, and Tampa.

2. The combined Florida Construction Cost Inflation Index from Step l is projected one semester forward by assuming that the change in the index over the six months will equal the change in the last six months. Thus:

   $$\text{Projected Index Value} = \frac{\text{Last Index Value}}{\text{Next-to-last Index Value}} \times \text{Last Index Value}$$

   For example, the March 1984 average value is 1700.02 and the September 1983 average value is 1688.27 (using the March 1984 publication), so that:

   $$\text{Projected March 1984 value} = \frac{1700.02}{1688.27} \times (1700.02) = 1711.85$$

3. The semiannual index values obtained in Steps 1 and 2 are used to obtain monthly Florida Construction Cost Index values. The monthly index value m months past the previous index is computed as follows:

   $$\text{Monthly Value m Months Past Previous Index} = \left(\frac{\text{Next Index Value}}{\text{Previous Index Value}}\right)^{m/6} \times \text{Previous Index Value}$$

   For example, using the September 1983 and March 1984 values given above, the interpolation formula yields

   $$\text{October 1983 Index} = \left(\frac{1700.02}{1688.27}\right)^{1/6} \times 1688.27 = 1690.22$$

   $$\text{November 1983 Index} = \left(\frac{1700.02}{1688.27}\right)^{2/6} \times 1688.27 = 1692.17$$

These indices will be updated semi-annually prior to each January 1 and July 1 using the most recent publication of the Dodge Indices.

Appendix B
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FOR RATES EFFECTIVE ON AND AFTER 7/1/91

The Florida Construction Cost Inflation Index is calculated from Health Care Costs published by DRI/McGraw-Hill using the CPI All Urban All Items Regional Index for the South Region. The Florida Index is calculated by the following steps:

1. Using the most recent Health Care Costs publication, locate the tables containing the Consumer Price Index All Urban All Items.

2. Using the South Region, divide the index corresponding to the midpoint of the current rate period by the index of the midpoint of the previous rate period. The results shall be the inflation multiplier for the rate semester.

Example:

Rate Semester - January 1991

Publication - DRI/McGraw-Hill Health Care Costs, Third Quarter 1990, Page 18, Table 6.

Quarter	Index	Average Index	Corresponding Month
1991:2	1.041	1.0345	March 31
1991:1	1.028		
1990:4	1.014	1.007	September 30
1990:3	1.000		

6 month inflation multiplier =
(1.0345/1.007) =
1.027308 or
2.7308 % increase over 6 months.

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